Ashley Jackson DDS PLLC

E-Mail: ajacksondds@tylerfamilydentist.com **Phone: 903-593-2313**
1211 Clinic Drive **Fax: 903-597-7033**
Tyler, TX 75701 **Website: TylerFamilyDentist.com**

Patient Information

Patient Name: ____ Date: ____________________
Last First MI

Preferred Name: ________________________

Male Female Married Single Child Other _____________

Social Security #: _____________________________ Birth Date: ___________________ Age: ________

Home Number: ________________________ Work Number: ________________________ Ext: ________

Cell Number: __________________________

Address: ____
Street Apt #

____
City State Zip Code

E-mail Address: ____

Employer: ____ Occupation: __________________________

Responsible Party Information (If different than patient):

If a minor is brought in for treatment, the adult seeking the treatment is responsible for payment, regardless of who carries the insurance policy or who has custody.

Name of Person Responsible for this Account: ____

Relationship to Patient: _________________________ Social Security #: ___________________________

Birth Date: ___________________

Home Number: ________________________ Work Number: ________________________ Ext: ________

Cell Number: __________________________

Address: ____
Street Apt #

____
City State Zip Code

Date of Last Dental visit: _____________________ Reason for today's visit: _____________________________

Date of Last Cleaning: _______________________ Date of last dental x-rays: ___________________________

How often do you floss? ______________________ How often do you brush? ____________________________

Former Dentist: _____________________________ City/State: _______________________________________

Was your pattern of visits: regular infrequent sporadic

Referral Information:

Whom may we thank for referring you to our practice?

Patient, Friend/Relative Another Dental Office

Name of Person or Office referring you to our practice: ____

Yellow pages School Work Website/Internet

In case of emergency, please list a friend or family member not in your same household:

Name: ____ Home Number: _______________________________

Work Number: ________________________________ Cell Number: ________________________________

Medical History:

List medications you are currently taking: ____

____

____

Pharmacy Name: ____________________ Phone Number: ____________________

Have you ever had any complications during or following dental treatment? Yes No

If yes, please explain: ____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: ____

Are you now under the care of a physician? Yes No

If yes, please explain: ____

Name of Physician: ____________________ Phone Number: ____________________

Do you have any health problems that need further clarification? Yes No

If yes, please explain: ____

Are you using any recreational drugs? Yes No

Are you accustomed to regular dental cleanings and check-ups? Yes No

Are you happy with the appearance of your smile? Yes No

Do you wish to be shown how we can improve the look of your smile? Yes No

Do you expect to keep your teeth for your lifetime? Yes No

What do you expect most from your dentist? ____

Please list any other pertinent information you need us to know to better serve your dental needs: ____________________

____

Are you allergic to or have you had any reactions to the following?

Aspirin Local Anesthetic Codeine Penicillin

Sulfa Latex Other____________________

Have you ever had any of the following? Please check those that apply:

Heart Problems/Disease
- Artificial Joint/Valves
- Premed needed for Dental Treatment
- Heart Murmur

Lung/Respiratory Disease
- Asthma
- Emphysema
- Sinus Problems

Arthritis/Rheumatism
- Lupus
- Multiple Sclerosis
- Fibromyalgia

Blood Disease
- Anemia
- Excessive Bleeding
- Other____________

Rheumatic Fever
High Blood Pressure
Low Blood Pressure
Mitral Valve Prolapse

Hay Fever
Tuberculosis
Liver Disease
- Jaundice

Other autoimmune disease: ____________________
Mental Disease
- Psychiatric care

AIDS
HIV
Herpes
- Venereal Disease

Pace Maker
Tumors/Growths
Chemo Date: ________
Radiation Date: _______

Hepatitis Type _____
Diabetes Type _______
Epilepsy
Osteoporosis

Chemical Dependency
Nervous Disorder
Head Injury
Dizziness/Fainting

Women Only:
Pregnant at THIS time
- Due Date: __________
Taken Biophosphates

Have you ever had any of the following? Please check those that apply:

Sensitivity to
- Hot
- Cold
- Sweets
- Pressure when chewing

Dry mouth

Have you had prior:
- Periodontal treatment
- Orthodontic treatment
- TMJ treatment

Smokeless tobacco
Cig/Pipe/Cigar smoke

Loose teeth/Broken fillings
Jaw pain or tiredness
Clicking or popping jaw
Pain around ear
Grind/Clench teeth
Bad Breath

Swollen or tender gums
Sores or growths in mouth
Chew on one side of mouth
Food collection between teeth
Radiation to head/neck

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

______________________________ ____________________

Signature of patient, parent or guardian Date

FINANCIAL AGREEMENT

We are happy to assist you in verifying your benefits and maximizing them to your fullest financial advantage. We will assist you in preparing forms or printing receipts for you to file with your insurance company; or if we file insurance claims on your behalf, we will need a copy of your current insurance card; you are required by your insurance company to pay all co- pay's, coinsurance, and deductibles which are due and payable at the time of service.

Verification of your insurance does not guarantee payment. Payment is subject to review by your insurance company and is determined upon the actual receipt of the claims by the insurance company. Dr. Jackson's office will file an initial insurance claim on my behalf at no additional cost. If my insurance carrier has not responded or denies payment within 45 days of the date of the service the entire fee for the service is due and payable by me. I understand any remaining balance regardless of the amount of the insurance payment is my responsibility and it is my responsibility to contact your insurance company to dispute any denial, or nonpayment issues.

Authorization to pay benefits to dentist: I hereby authorize payment directly to the above dentist for the surgical and or dental benefits, if any, otherwise payable to me for services as described above but not to exceed the benefits provided for covered services.

I, ______________________, understand that any service performed for my dependant or me by Dr. Jackson or her office is my personal financial responsibility. If I have dental insurance I understand that it is not Dr. Jackson's office responsibility to collect from my insurance company. I, the insured/dependant, have read the above and understand the policies regarding office financial and insurance policies. I agree to comply with all policies and agree to be responsible for payment of all services at the time rendered.

____

Patient/Guardian Signature Date

CANCELLATION POLICY

I understand that I need to arrive at the appropriately scheduled time for treatment. The doctor and hygienist have numerous duties encompassed by their schedule. Therefore, the facility asks that you arrive at your appropriately scheduled time.

Arriving excessively early will not ensure or entitle you to begin your appointment early.

Likewise, tardiness in excessive of 15 minutes may require rescheduling of the appointment or modification of your treatment. We do our best to run on time. The nature of our practice is to give our patients the utmost care and service. Please excuse any delays on our part. We will give you the same careful attention as soon as possible.

In the event that you do need to cancel or anticipate being late- please call us at (903)593-2313 before your scheduled treatment time. We request a 24-business hour notice for all cancellations. Failure to do so may be subject to a $50.00 charge.

The schedule is available by first come first serve basis. Canceling minutes or hours before an appointment or not showing for an appointment may prevent other patients from scheduling. Again, we request a 24-business hour notice for all cancellations; otherwise you will be subject to a $50.00 charge. Excessive abuse of the schedule, arriving late (more than 15 minutes) or not showing up three (3) or more times may result in dismissal from our office. We will try out very best to accommodate your schedule within our available resources. Your assistance and understanding is appreciated.

____

Printed Name

____ ________________

Signature of Patient or Guarantor Date

PATIENT ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: ________________________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

________________________________ ________________________________

Print Patient Name Patient Signature/Guardian of Patient

________________________________ ________________________________

Guardian/Legal Representative Relationship of Guardian/Legal Representative

HOW DO YOU WANT TO BE ADDRESSED WHEN CALLED BACK FROM THE RECEPTION AREA:

First Name Only Proper Sur Name Other________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

Cell Phone Work Phone

Home Phone **Any of the Above**

I AUTHORIZE ADDITIONAL METHODS OF CONTACT VIA:

Text Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY- *(do not fill out)*

As Privacy Office, I attempted to obtain the patient's (or representative) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

Other Please describe: ________________________________ ________________________________

Signature of Privacy Officer